

CASE HISTORY

Date: _____

How did you hear about us? _____

Name _____ Age _____ Date of Birth ____/____/____

Address street _____ City _____ State _____ Zip _____

Address PO Box _____

Sex: M F Marital Status: S M D W Social Security# _____

Phone (Home) _____ (Cell) _____ Work _____

Occupation Employer _____

Insurance Company _____

Spouse's Name _____ Spouse's Occupation _____

Present condition due to an injury? Yes No If Yes, Was it? on the Job Auto Accident Other

Has the accident been reported? Yes No

Emergency Contact: _____ **Phone** _____

HEALTH REPORT:

Reason for seeking care: _____

List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? Yes No If yes, explain: _____

List the names of any relatives that have or have had a similar problem: _____

Have you or any relative received chiropractic treatment previously? Yes No

If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, explain: _____

Are you currently taking medication? Yes No list medications: _____

Have you taken medication in the past? Yes No list medications _____

List conditions you are taking medications for: _____

List the approximate dates of any surgery or treated conditions: _____

Family History: Health conditions, age of death and cause of death.

Father: _____ Mother: _____ Siblings: _____

Do you smoke Y/N ____ · Alcohol Y/N __Daily __Weekly __Social Occasions · Caffeine Drinks ____?

Do you take Vitamins/Supplements Yes No If yes, type and how often _____

Please circle degree of pain, 0 none, 10 severe pains.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel Pain.

Numbness = = = Dull Ache O O O
Burning X X X Sharp/Stabbing / / /
Pins, Needles + + + Other ^ ^ ^

What activities aggravate your condition/pain? _____

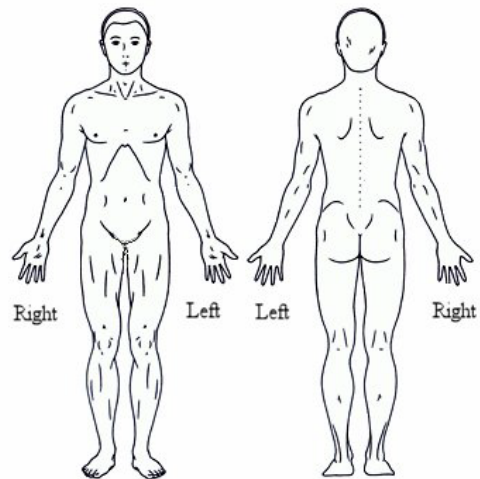
What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work? _____

Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? _____



Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder

Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy

FOR WOMEN ONLY

- Birth Control
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient

Signature _____ Date _____